12-10- uepak	26 16:39	DC0547PM13501 HAND HUMAN SERVICES	865	2125642 >> 42	234681554 P	. 10/20/2
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	54	12101112	FORM OMB NO	APPRO
TATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDINI	PLE CONSTRUCTION	(X3) DATE S	URVEY
		445205	B. WING	······································		
IAME OF F	ROVIDER OR SUPPLIER	440200				7/2012
	ATE HEALTH CARE	OF CHATTANOOGA	82	EET ADDRESS, CITY, STATE, ZIP C 249 STANDIFER GAP ROAD	ODE	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		HATTANOOGA, TN 37421		·
PRÉFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) Preparation and/or execu	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
E 000	INUTIAL COMMENT			of correction does not co		
F 000	INITIAL COMMENT	'S	F 000	admission or agreement t		
ı				with the statement of def		
	Amended: October	26, 2012		plan of correction is prep		
F 156	483.10(b)(5) - (10),	483.10(b)(1) NOTICE OF	F 156	executed because it is rec		
SS=D	RIGHTS, RULES, S	SERVICES, CHARGES		provision of Federal and		S.
j	The facility must info	orm the resident both orally	-	F 166		
	and in writing in a la	nguage that the resident		F-156		
i	understands of his o	or her rights and all rules and	!	1 D 11 1 105	#464	
	regulations governing	g resident conduct and		1. Residents #95,		
ı I	responsibilities durin	ig the stay in the facility. The			harm. Resident	7
1	facility must also pro	vide the resident with the		95 was sent a M	1	
}	notice (if any) of the	State developed under	j		12. Resident #4	
	§1919(e)(6) of the A	ct. Such notification must be			care denial letter	
	made prior to or upo	n admission and during the	i	on 10-18-12. Re		
	resident's stay. Rec	eipt of such information, and	•	provided with a		
}	any amendments to	it, must be acknowledged in		Resident's Righ		
	writing.	_	ľ	2. The facility's B		
ļ	 			Manager review		
- 1	I ne facility must info	rm each resident who is		facility residents		
 	entitled to Medicald (penefits, in writing, at the time		appropriate liabi	rm of a Medicar	~
	n admission to the h	ursing facility or, when the	-	denial letter hav		5
	resident becomes en	gible for Medicaid of the		++		
1.3	facility services (r	nat are included in nursing	ļ	during the last 3		
- 1,	which the recident m	r the State plan and for ay not be charged; those			current resident having received	
18	other items and servi	ices that the facility offers	ļ	a Medicare deni		
. 2	and for which the res	ident may be charged, and		applicable, was		
1	he amount of charge	es for those services; and		appropriate liabi		
i	nform each resident	when changes are made to			lity's Admission	ı
/ t	he items and service	s specified in paragraphs (5)			iewed all current	
(i)(A) and (B) of this s	section.	İ	facility residents		
İ		1		they received a	1	
1	The facility must infor	m each resident before, or		Resident's Right		
ļ ē	at the time of admissi	ion, and periodically during		admission to the		
į t	he resident's stay, of	services available in the	ļ		s identified as no	t
fi	acility and of charges	s for those services.			a written copy o	
įi	noluding any charges	for services not covered		Resident's Right		
- 1		the facility's per diem rate.				
ATORY D	IRECTOR'S OR PROVIDER	MISUPPLIER REPRESENTATIVE'S SIGNA	TURE .	TITLE) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; R92211

Facility ID: TN3314

DC0547PM13501

DEPARTMENT OF HEALTH AND HUMAN SERVICES

8652125642 >>

4234681554 P 3

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		445205	B. WIN	IG			10/17/2012	
	PROVIDER OR SUPPLIER ATE HEALTH CARE	OF CHATTANOOGA	'	82	EET AOORESS, CITY, STATE, ZIP 49 STANDIFER GAP ROAD HATTANOOGA, TN 37421		07.112012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 156	legal rights which in A description of the personal funds, und section; A description of the for establishing eligithe right to request 1924(c) which deternon-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his edown to Medicaid elements of all pertingroups such as the agency, the State licombudsman program advocacy network, a unit; and a statement complaint with the Sagency concerning in misappropriation of facility, and non-condirectives requirements. The facility must corspecified in subpart related to maintaining procedures regarding requirements included.	mish a written description of cludes: manner of protecting der paragraph (c) of this requirements and procedures ibility for Medicaid, including an assessment under section mines the extent of a couple's ces at the time of a dattributes to the community a share of resources which ad available for payment the institutionalized spouse's for her process of spending ligibility levels. addresses, and telephone ment State client advocacy State survey and certification censure office, the State m, the protection and and the Medicaid fraud control at that the resident may file a state survey and certification resident abuse, neglect, and resident property in the appliance with the advance ents. In of part 489 of this chapter g written policies and g advance directives. These as provisions to inform and	F1	56	admission was copy. The Reg Office Manager facility's Busin Manager on the and Procedure denial letters to appropriate no residents of the appeal. The Regidents of the appeal. The Regidents of the appeal of the appearment or Policy and Procedure resident of Policy and Procedure resident their Resident's. The facility's Administratory Clinical Service Manager will of Improvement of Medicare denial appropriate no appeal for resifacility's Administratory of Clinical Service Manager will of Manager will of Manager will of Clinical Service Manager will of Manager will	gional Busines or re-educated ness Office he facility's Pol-for Medicare of ensure diffication to eir liability and egional Direct educated the issions of the facility's deduce of Residuced of Residuc	sthe licy I or of ffice y g of sure ctor duct	
		nation to all adult residents			Clinical Service	es will report		

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: R9ZZ11

Facility ID: TN3314

If continuation sheet Page 2 of 34

2012-10-26 16:39 DC0547PM13501 8652125642 >> 4234681554 P 4 DEFARTMENT OF HEALTH AND MUMAN SERVICES FRINTED: 10/20/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 445205 10/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) results of QI monitoring to the F 156 | Continued From page 2 Quality Assurance/Performance F 156 Improvement (QA/PI) concerning the right to accept or refuse medical Committee monthly x 12 months or surgical treatment and, at the individual's for continued compliance and/of option, formulate an advance directive. This revision. includes a written description of the facility's policies to implement advance directives and Substantial Compliance 12-1-12 applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:

Based on review of facility documentation, interview, and medical record review, the facility failed to provide two residents (#46, #95) of three residents reviewed with an appropriate liability and appeal notice, and failed to provide resident rights in writing for one resident (#11) of forty-three sampled residents.

The findings included:

FORM CMS-2567(02-99) Previous Versions Obsolote

Review of facility documentation for two residents #46, and #95, revealed no denial letter and the beneficiary had not been advised of his/her rights to have a claim submitted to Medicare or advise the standard claim appeal rights if the claim was denied by Medicare.

Event ID: R9ZZ11

Facility ID: TN3314

If continuation shoot Page 3 of 34

DEPAR	26 16:39 TMENT OF HEALTH RS FOR MEDICARE	DC0547PM13501 I AND HUMAN SERVICES & MEDICAID SERVICES	86	52125642 >> 423	FORM	P 5/35 D: 10/26/2013 MAPPROVED D: 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BVILDII	TIPLE CONSTRUCTION	(X3) DATE S	SURVEY
		445205	B. WING		400	17/0040
NAME OF R	PROVIDER OR SUPPLIER		ŜΤ	REET ADDRESS, CITY, STATE, ZIP CO		17/2012
CONSUL	ATE HEALTH CARE		{	9249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421		
(X4) ID PREFIX TAG	 (EACH DEFICIENCY 	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 156	Continued From page	ge 3	F 156			
	2012, at 4:28 p.m., i the facility failed to p and/or appeal notice Resident #11 was at 21, 2012, with diagn Disorder, Depressive Atrial Fibrillation, and Medical record revie Data Set dated Auguresident had no cogn Interview with the res at 9:00 a.m., in the res	dmitted to the facility on May oses including Personality e Disorder, Hypertension, d Congestive Heart Failure. w of the quarterly Minimum ust 30, 2012, revealed the nitive impairment. sident on October 17, 2012, esident's room, revealed the never recieved a copy of the				
	2012, at 10:40 a.m., i confirmed the resider the admission paper indicating, "I hereby a received copies of the that it has been clear facility staff. Patient I confirmed the admiss	documentation and cial Worker on October 17, in the conference room, in thad signed and initialed all work except the section acknowledge that I have a following information and by explained to me by the Rights" Further interview sion documentation did not thad received a written conv		F-221		

FORM CMS-2567(02-99) Previous Versions Obsolete

of the Patient Rights.

SS=D PHYSICAL RESTRAINTS

F 221 483.13(a) RIGHT TO BE FREE FROM

The resident has the right to be free from any

discipline or convenience, and not required to

physical restraints imposed for purposes of

Event ID: R92211

Facility ID: TN3314

F 221

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Resident #1 suffered no harm.

Resident #1's 1/2 side rails were

at the head of the bed to aid the

resident with turning and

removed from the center of the bed and ¼ padded side rails were placed

CENTE	RS FOR MEDICARE	DC0547PM13501 I AND HUMAN SERVICES & MEDICAID SERVICES	86	521256	42 >> 	F	P 6/3 NEU: 10/20 ORM APPRI NO. 0938	6/201 OVE
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONS	TRUCTION	(X3) D	ATE SURVEY OMPLETED	
		445205	B. WING		<u> </u>	.]	40471004	_
CONSU	PROVIDER OR SUPPLIER			8249 STAN	RESS, CITY, STATE, I DIFER GAP ROAD NOOGA, TN 3742		<u>10/17/201;</u>	<u>z_</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(E	PROVIDER'S PLAN C ACH CORRECTIVE A SS-REFERENCED TO DEFICIE	CTION SHOULD BE DITHE APPROPRIAT	E COMPL	
F 221	treat the resident's resident the resident's resident to resident to resident to residents. This REQUIREMEN by: Based on medical read interview, the fapre-restraining asset for a restraint for one residents reviewed or residents. The findings included Resident #1 was adread 23, 2002, and readments.	medical symptoms. IT is not met as evidenced ecord review, observation, cility failed to complete a ssment and obtain an order e resident (#1) of three of forty-three sampled d: mitted to the facility on July bitted July 22, 2011, with Dementia. Anxiety Left	F 221	2.	the physician's #1's Velcro sel seat belt was di alarm was appl per the physicia The facility's I Services/Nurse all current facil ensure that any restraint curren appropriately a placement of th physician's ord that restraint. identified as no assessment for current physician	Director of Clinic Manager review it yes idents to be residents with a sessed prior to the restraint and ther was in place Any residents of having had a part of the control of the contro	ming a tab lchair cal wed been the a for	

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been completed.

with alarm..."

Medical record review of the quarterly Minimum

decision making, was totally dependent on staff

Medical record review of the Care Plan dated

March 6, 2012, revealed "...1/2 rails for increase

mobility and safe turning...velcro self release bett

Medical record review revealed no pre-restraining

Medical record review of the Quarterly Collection

restraints, and the side rail assessment had not

Data dated August 11, 2012, revealed no

assessment had been completed.

for bed mobility, transfers, and no restraint in use.

the resident was cognitively intact for daily

Data Set (MDS) dated August 20, 2012, revealed

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If continuation sheet Page 5 of 34

discontinued until which time the

assessment was completed and the

The Regional Director of Clinical

Services re-educated the facility's Director of Clinical Services/Nurse

Managers on the facility's Policy

and Procedure for Restraints. The

Services/Education Coordinator reeducated all current facility nursing

staff on the facility's Policy and

Services/ Nurse Manager will

to ensure that an assessment is

conduct QI monitoring of restraints

completed and a physician's order

Procedure for Restraints.
The facility's Director of Clinical

facility's Director of Clinical

physician's order was obtained.

CENTE	ERS FOR MEDICARE	DC0547PM13501 H AND HUMAN SERVICES E & MEDICAID SERVICES			125642 >> 4234	FORM	1732 : 10/29/20 APPROVE <u>. 09</u> 38-039
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	AULTIP!	E CONSTRUCTION	(X3) DATE S	URVEY
		445205	8. WI	NG		40/4	7/2012
	PROVIDER OR SUPPLIER	OF CHATTANOOGA		824	EY ADDRESS, CITY, STATE, ZIP CODE 19 STANDIFER GAP ROAD ATTANOOGA, TN 37421		(120 1 <i>2</i>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
	recapitulation orders through October 31, side rails up x (times bed to aid in bedside self-release belt with to alert staff of unsa. Medical record revie Progress Note dated "no restraints" Observation on October in a reclining wheeld belt in place. Observation on October in the bed with one-half middle of the bed, an Interview with the Ass (ADON) on October nurse's station, confinition assessed as a self-release belt in place.	ew of the physician's s dated October 1, 2012, , 2012, revealed "11/28/11; es) 2 bilat (bilateral) while in le positioning7/22/11; Velcro th alarm to W/C (wheelchair)	F2	221	is obtained prior to respect resident. QI monitoring conducted 3 x weekly using a sample size of 4. The facility's Director Services/ Nurse Manareport results of QI months for continued and/or revision. Substantial Compliance	ng will be for 12 weeks 6. of Clinical ger will onitoring to monthly x 12 compliance	

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the bed.

Interview with the Director of Nursing (DON) on October 17, 2012, at 8:24 a.m., at the nurse's station, confirmed the the side rails had not been assessed as a restraint and if the resident wanted to exit the bed the resident would go to the foot of

Observation and interview with the Nurse Consultant on October 17, 2012, at 1:05 p.m., in

Event ID: R92211

Facility (D; TN3314

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DEPAR CENTE	RS FOR MEDICARE	DC0547PM13501 H AND HUMAN SERVICES E & MEDICAID SERVICES	8	36521256	42 >> 42	FORM	8/35 . 10/20/2012 ! APPROVED . 0938-0391
STATEMEN' AND PLAN (IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CON LDING	STRUCTION	(X3) DATE S COMPLI	URVEY
	_	445205	B. WIN	G		10/1	7/2012
CONSUL	PROVIDER OR SUPPLIER			6249 STA	PRESS, CITY, STAYE, ZIP C NDIFER GAP ROAD NOOGA, TN 37421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION FREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 221	Continued From pa		F 2:	21 F-246			
i 	unable to remove the command and the table seat belt as a restra			1.	Residents # 23 and no harm. Resident call light placed wi	#23 had their	
F 246 SS=D	483.15(e)(1) REAS OF NEEDS/PREFE	ONABLE ACCOMMODATION RENCES	F 24	46	on 10-15-12. Residen call light placed wi		
	A resident has the reservices in the facili	right to reside and receive		2.	on 10-17-12. The facility's Dire		

This REQUIREMENT is not met as evidenced by:

accommodations of individual needs and

the individual or other residents would be

preferences, except when the health or safety of

Based on medical record review, observation, and interview, the facility failed to provide a call light within reach for two residents (#23,#104) of twenty-seven residents reviewed of forty-three sampled residents.

The findings included:

endangered.

Resident #23 was admitted to the facility on May 19, 2008, with diagnoses including Multiple Sclerosis, Paralysis Agitans, Hypertension, Peripheral Vascular Disease, Latent Nystagmus. External Ophthalmoplegia, and Depressive Disorder.

Medical record review of the Care Plan dated October 10, 2012, revealed "Self Care Deficit" with approaches and interventions including "... Keep needed items in easy reach, Call bell in reach..."

- Services/Nurse Managers/Social
 Services reviewed all current
 facility residents to ensure that their
 call lights were placed within their
 reach. Any current facility
 residents identified as not having
 had their call lights within their
 reach immediately had their call
 light placed within their reach. The
 facility's Director of Clinical
 Services/Nurse Manager reeducated all current facility staff on
 the facility's Policy and Procedure
 for Call Lights to ensure that they
 are within the resident's reach.
- 3. The facility's Director of Clinical Services/Nurse Manager will conduct QI monitoring of call lights to ensure that they are within the resident's reach. QI monitoring will be conducted 5 x weekly for 4 weeks then 3 x weekly for 8 weeks, then 1 x monthly for 9 months using a sample size of 6.
- Services/Nurse Manager will report results of QI monitoring to the

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2012-10-26 16:40 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DC0547PM13501

8652125642 >>

4234681554 P 9/35

FORM APPROVED

CENTE	<u>RS FOR MEDICARI</u>	E_& MEDICAID SERVICES). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		STRUCTION	(X3) DATE S	URVEY
l		445205	B. WING	·		100	17/0040
	PROVIDER OR SUPPLIER ATE HEALTH CARE	OF CHATTANOOGA	5	8249 STA	PRESS, CITY, STATE, ZIP CODE NDIFER GAP ROAD NOOGA, TN 37421	<u>1 1ur</u>	17/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Observation on Oc revealed the reside privacy curtain pull revealed the call lig the bed.	tober 15, 2012, at 3:50 p.m., and lying on the bed with the sed. Continued observation the on the floor at the head of	F 24	6	QA/PI Committee mont months for continued co and/or revision. Substantial Compliance		
	Records Director of p.m., confirmed the the resident would needs or an emergineeds or an emergineed at \$104 was October 6, 2009, which is the properties of	terview with the Medical n October 15, 2012, at 4:00 call light was on the floor and not be able to alert the staff of ency. admitted to the facility on ith diagnoses including; disorder, Hypertension, T Disease, and Cerebral					
	11, 2012, revealed approaches and introneeded items in east Observation on Oct and at 8:45 a.m., re	ew of the Care Plan dated July "Self Care Deficit" with erventions including "Keep sy reach, Call bell in reach" ober 17, 2012, at 8:30 a.m. vealed the resident lying in ntinued observation revealed		F-250			
F 250 \$S=D	the call light was no and was located at: Interview with the C October 17, 2012, a resident could use on not within reach. 483.15(g)(1) PROVI RELATED SOCIAL	t within reach of the resident the foot of the bed, ustomer Care Liaison, on it 8:55 a.m., confirmed the call light was SION OF MEDICALLY	F 250	2.	Resident # 6 suffered not Resident #6 has an appose an oral surgeon on 1 the Director of Social Se arranged transportation. The facility's Director of Services/Nurse Manager all current facility reside ensure that they had rece	intment to 1-7-12 and ervices has f Clinical reviewed nts to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R92Z11

Fadiliy ID: TN3314

If continuation sheet Page 8 of 34

UEFAR	·26 16:40 TIMENT OF HEALTH RS FOR MEDICARE	DC0547PM13501 1 AND HUMAN SERVICES <u>E& MEDICAID S</u> ERVICES	ł	36521256	642 >>	42346	FORM	APPROVE	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M	ULTIPLE CON: LDING	STRUCTION		OMB NO (X3) DATE S COMPLI		
	_	445205	B. WIN	-		_			
NAME OF	PROVIDER OR SUPPLIER	,	 -	ATCEET 455			10/1	7/2012	
CONSU	LATE HEALTH CARE	<u> </u>		8249 STAP	RESS, CITY, STATE, 2:P NDIFER GAP ROAD NOOGA, TN 37421	CODE			
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	< (E	PROVIDER'S PLAN OF EACH CORRECTIVE ACT DSS-REFERENCED TO T DEFICIENCE	TON SHO! THE APPR	ULD AF	(XS) COMPLETION DATE	
F 250	Continued From page services to attain or practicable physical well-being of each relationship.	maintain the highest mental, and psychosocial	F 2	50	services in the pa needed follow-up services had been current facility re as not having rec services and/or a	p for de n compl esidents eived d ny need	ntal leted. Any identified lental led follow		
	by: Based on medical r and interview, the fa dental services, for o resident's reviewed o resident's. The findings includes				up for dental servappointment schedentist, as applic Director of Cliniceducated the faci Administrator, D Services and faci Social Services of Policy and Proce of Dental Service Director of Cliniceducated the service of Dental Service Director of Cliniceducated application of	eduled table. To cal Servility's Director ility's Don the factor idure for the call to the call the ca	to see the The Region Vices re- Of Clinical Director of acility's r Provision		
	23, 2008, with diagnous Delusions, Hyperlipid Dementia Behavior, Esophageal Reflux a Medical record review Data Set (MDS), date the resident was cog	demia, Senile Depression, Depressive Disorder, and Diaphragmatic Hemia, w of the annual Minimum and July 13, 2012, revealed		3.	Services/Director Services/Educati educated all curre Department Man well as all curren the facility's Poli for the Provision Services.	r of Soc on Coor ent facil agemen it nursin icy and of Den	rdinator re- lity it staff, as ig staff on Procedure tal		

FORM CMS-2567(02-99) Previous Versions Obsolote

Medical record review of the Annual Dental

"...teeth...upper several broken teeth...lower

several broken teeth...Dr. (named physician)

Conference Record, dated January 5, 2012,

daughter...resident has bad teeth, dental consult,

Exam, dated February 3, 2012, revealed

Center for Oral and Facial Surgery..."

Medical record review of the Care Plan

revealed "...conference call with

Event IO: R9ZZ11

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will conduct QI monitoring to

any additional follow-up dental

monitoring will be conducted 3 x weekly for 4 weeks, then 1 x

services, as applicable. QI

weekly for 8 weeks, then 1 x

monthly for 9 months using a

sample size of 6.

ensure that facility residents receive

dental services at least yearly and/or

2012-10-26 16:40	DC0547PM13501
DEPARTMENT OF HEALTH	AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES
STATEMENT OF DESIGNATION	444 DD-149-0-1-1-1

8652125642 >>

4234681554 P 11/35 PKINTED: 10/26/2012 FORM APPROVED OMB_NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) I	KI II TIP	I E CONS	TRUCTION	-	<u>J. 0930-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	- 1	ILDING		TROUION	(X3) DATE COMP	SOKVET LETED
)		445005	B. WI				}	
NAME OF	PROVIDER OR SUPPLIER	445205	B. 741				10/	17/2012
						RESS, CITY, STATE, ZIP CODE DIFER GAP ROAD		
CONSU	LATE HEALTH CARE	OF CHATTANOOGA		•		100GA, TN 37421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	IX	(E	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
	<u> </u>				5110	DEFICIENCY)	-NOLKRAIC	
F 250	Medical record revidence and an appointment Telephone interview member on Octobe revealed the continuous and appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member on October and an appointment interview member and appointment interview member and an appointment interview member and appointment inter	iew of the Care Plan, dated ealed "has poor dentationis for oral carearrange follow ith dentist as indicated" ew of the Social Service ited January 5, 2102, revealed ame) recommended resident e for cleaning and to get teeth it cannot be done in the resident's family) does not sportationsocial worker will		250	4.	The facility's Director Services/Social Service will report results of Q to the QA/PI Committe 12 months for continue compliance and/or revisual Substantial Compliance	es Director I monitorir ee monthly ed ision.	ng .
	arrange the transpo residentresident is get the chair in the v	rtation by ambulance for the in a geri-chair and we cannot rehicle and we need an pointment was cancelled and						
F 252 SS=D	October 17, 2012, a Nurses Station, confollow up on the app transportation for the 483.15(h)(1)	poial Service Director on t 1:00 p.m., in the East firmed the facility falled to ointment and arrange a resident.	F 2!		F-252 1.	Resident # 1 suffered n Resident #1 had a telev and flowers placed in h request on 11-16-12.	ision, cloc	'
				-				

CENTE	RS FOR MEDICARE	DC0547PM13501 HAND HUMAN SERVICES E&MEDICAID SERVICES	8	365212	5642 >>	FOR	D: 10/20/20 M APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		DNSTRUCTION	(X3) DATE	<u>O. 0938-039</u> SURVĘY PLETED
		445205	B. WIN	G			
	PROVIDER OR SUPPLIER LATE HEALTH CARE	OF CHATTANOOGA		8249 \$1	ODRESS, CITY, STATE, Z ANDIFER GAP ROAD	IP CODE	<u>/17/2012</u>
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	ANOOGA, TN 3742' PROVIDER'S PLAN O (EACH CORRECTIVE AC PROSS-REFERENCED TO DEFICIENT	F CORRECTION OTION SHOULD BE THE APPROPRIATE	COMPLETIO DATE
	The facility must procomfortable and hor the resident to use to the extent possible. This REQUIREMENT by: Based on observation failed to provide a hor resident (#1) of twent of forty-three sample. The findings included Resident #1 was addred and readmed and readmed and resident was addred and resident was addred and resident was contained and resident was contained and resident for all active resident in use, and included.	ovide a safe, clean, melike environment, allowing his or her personal belongings le. IT is not met as evidenced on and interview the facility omelike environment for one aty-seven residents reviewed ed residents. d: mitted to the facility on July hitted July 22, 2011, with Dementia, Anxiety, Left hemia. w of the quarterly Minimum and August 20, 2012, revealed nitively intact, totally vities of daily living, no incontinent of bowel and	F 25		2. The facility's I Services/Direct reviewed all cuensure that the them with a how Any current results in their environment homelike. The Clinical Services/Direct on the facility's Direct Services/Direct Services/Direct Services/Direct Services/Direct Services/Direct Services/Educated all cuenthe facility's Procedure on the facility's Procedure all cuenthe facility's Procedure on the facility's Proceducated all cuenthe facility's Procedure on Environment. 3. The facility's Direct Services/Direct will conduct Quensure a homel	Director of Clinicator of Social Serving arrent residents to facility is providing melike environments identified a smelike environment is one that is Regional Director es re-educated the tor of Clinical tor of Social Serving Policy and Provision of a fronment. The tor of Clinical tor of Social serving and Provision of a fronment. The tor of Clinical tor of Social serving and Procedure for Social serving and Procedure for Social serving and Procedure for Social serving and Procedure for Social Serving and Procedure for Soc	of ces
i	the resident's room, r n a reclining wheelch place, and teeth in po pbservation at this tin	evealed the resident seated lair, self release seat belt in our condition. Further the revealed the resident had a, knickknacks, or personal			conducted 3 x v then 1 x weekly	I monitoring will weekly x 4 weeks, y for 8 weeks, ther months using a 6.	

FORM CMS-2587(02-99) Previous Versions Obsolete

items belonging to the resident.

Interview with the Social Service Director on

October 16, 2012, at 3:33 p.m., in the resident's room, confirmed the facility failed to provide a

Event IQ: R9ZZ11

Fecility ID: TN3314

If continuation sheet Page 11 of 34

4. The facility's Director of Clinical Services/Director of Social Services

will report results of QI monitoring

to the QA/PI Committee monthly x

CENT	ERS FOR MEDICARI	E & MEDICAID SERVICES						M APPROVED
STATEM.	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		MULTIPLE	CONST	RUCTION	(X3) DATE COMPL	
		445205	B WI	NG			10/	17/2012
	F PROVIDER OR SUPPLIER ULATE HEALTH CARE	OF CHATTANOOGA		8249	STANE	ESS, CITY, STATE, ZIP CODE DIFER GAP ROAD DOGA, TN 37421	101	17/2012
(X4) IE PREFII TAG	K (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAC	ıx	F (EA	PROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHOI S-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 25 SS=	maintenance servic	ge 11 ERVICES ovide housekeeping and es necessary to maintain a discomfortable interior	F:	253	4.	12 months for continued compliance and/or revision		
				F	-253			
	Based on observation failed to maintain and of sixty three resident failed to maintain a distribution of sixty three resident's. The findings include Observation on Octowith the maintenance hall, revealed the barrooms were torn from in the drywall at the too Observation on Octowith the maintenance hall, revealed a brow of the wall just outsid Interview with the maintenance hall, revealed a brow of the wall just outsid Interview with the maintenance hall, revealed a brow of the wall just outsid Interview with the maintenance hall, revealed a brow of the wall just outsid Interview with the maintenance hall, revealed a brow of the wall just outsid Interview with the maintenance hall, revealed a brow of the wall just outsid Interview with the maintenance hallway, confirmed the from the wall and in the side of the	ober 17, 2012, at 2 surp medication on the East Wing se boards in three residents in wall and cracks were found base of the wall ober 17, 2012, at 2.35 p medirector, on the East Wing in dried debris on the bottomie of a resident's bathroom			2.	The identified residents Wing suffered no harm. facility's Maintenance Director to be identified residents. East Wing on 10-19-12. Housekeeping Director rebrown debris located at the wall for one identified on the East Wing and cordeep cleaning of the iden resident's room on 10-19. The facility's Administrator/Maintenan Director/Housekeeping S reviewed all current residence intact and that the recoms were maintained in fashion. Any current residence in identified as not have being clean was correaccordingly. The facility Administrator re-educate facility's Maintenance Directory's Maintenance Directo	The irector ands for the on the The emoved the he base of d resident appleted a tified -12. The emoved the base of d resident appleted a tified as elean dent's wing tified as exted 's d the	
F 278 SS=E	483 20(g) - (j) ASSES ACCURACY/COORD	INATION/CERTIFIED	F 27	8		Housekeeping Supervisor facility's Policy and Proc Maintaining a Sanitary, C	on the edure for Orderly and	
	The assessment mus	i accurately reflect the				Comfortable Interior. Th	e racinty's	

CENTERS FOR MEDICARE	: AND FIDIVIAN SERVICES				FORM A	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MI A BUID	ULTIPLE CONSTRUC	j.	OMB NO. (X3) DATE SU COMPLET	
	445205	B WIN	G		10/17/2012	
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE	OF CHATTANOOGA		STREET ADDRESS, 8249 STANDIFE CHATTANOOG		10/1/	12012
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROV (EACH (AIDER'S PLAN OF CORRECTION SHOULD FERENCED TO THE APPRODEFICIENCY)	D RE	(x5) COMPLETION DATE
each assessment was participation of health assessment is completed in massessment is completed in massessment in a construction of the assessment must significant portion of the assessment in a construction of the constru	nust conduct or coordinate th the appropriate h professionals nust sign and certify that the leted completes a portion of the grand certify the accuracy of sessment. Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than somet, or an individual who y causes another individual and false statement in a is subject to a civil money can \$5,000 for each does not constitute a tement. Is not met as evidenced ford review, observation, ity failed to complete the DS) accurately for three its of twenty-rune residents.	F 2	Add Din man how Poil Mark Co 3. The Add Din mo fact that the fast corrupt the x w mo san 4. The Add Din mo mo corrus Sub F-278 1. Re no Day rev	eministrator/Maintenance rector re-educated all cursintenance staff and all cursekeeping staff on the falicy and Procedure for sintaining a Sanitary, Oromfortable Interior. The facility's ministrator/Maintenance rector will conduct QI enitoring to ensure that the facility's rooms have based are intact on the walls a rooms are maintained in hion. QI monitoring will inducted 5 x weekly for 4 weeks weekly for 4 weeks, then enthly for 9 months using a number of 6. The facility's ministrator/Maintenance rector will report results on the QA/PI Conthly x 12 months for compliance and/or revision. The stantial Compliance 12-the sidents #1, #122 and #6 tharm. The facility's Mintenance (MDS) Coordinate ised Resident #1's annual ed 2-27-12 to include decimal controlled the controlled and controlled the controlled decimal controlled and controlled decimal controlled and controlled decimal controlled decimal controlled and controlled decimal controlled and controlled decimal controlled decimal controlled and controlled decimal controlled and controlled decimal controlled and controlled decimal controlled and controlled decimal controlled and controlled an	rent urrent acility's derly and e e oards and that a clean l be weeks, s, then I l x a of QI ommittee ontinued 1-12 suffered nimum or al MDS	

CENTE		E & MEDICAID SERVICES					4 APPROVED 0. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		MULTIPLE COI	NSTRUCTION	(X3) DATE S	SURVEY
		445205	8 W	NG		400	17/2040
	PROVIDER OR SUPPLIER	05.00		STREET AD	DRESS, CITY, STATE, ZIP CODE	10/	17/2012
	LATE HEALTH CARE	OF CHATTANOOGA			NOOGA, TN 37421		
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F 278	Continued From pa	ge 13	F	278			
	diagnoses including Hemiparesis, and A Medical record revie Data Set (MDS) data revealed no dental in Observation on Octobervation on Octobervation on Octobervation on Octobervation on Octobervation of teeth in publical record revie Assessment dated uniformed gums, upporting the Medical record revier Collection dated July "condition of teeth gums bleeding, inflating the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Machanism of the Medical record review resident #1 dated Aurestraint in use	ew of the annual Minimum ted February 27, 2012 issues addressed ober 15, 2012, at 2:30 p.m., in revealed the resident seated chair, self-release seat belt in boor condition ew of an Admission July 23, 2002, revealed er dentures, and some ew of the Admission Data v. 22, 2011, revealed no dentures, edentulous, med gums, lesions present. "OS Coordinator responsible DS on October 16, 2012, at S office, confirmed a dental			issues related to missing inflamed gums and upper The facility's MDS Coorevised Resident #1's query MDS dated 8-20-12 to it restraints in use. The fate MDS Coordinator revised #122's quarterly MDS dated 12 to include impairment lower extremities. The MDS Coordinator revised #6's quarterly MDS dated to include that the resident glasses. The facility's MC Coordinator revised Residents and MDS dated 4-21 include broken teeth, and or bleeding gums. The facility's MDS Directive and MDS assessment in the past 90 days accurreflects the resident's staresidents identified as no been accurately assessed most recent MDS assess past 90 days, had a revise completed to accurately resident's status. The R Director of MDS re-educatility's Director of MID Director of Clinical Serving and Pro MDS Assessment Comp	er dentures. ordinator larterly nclude cility's ed Resident lated 8-27- at of the facility's ed Resident ed 7-13-12 ent wears ADS dident #6's -12 to d inflamed ector litty heir most completed rately atus. Any ot having I per their ment in the dion reflect the legional cated the DS and vices on the cedure for	
	Medical record review				ensure that the MDS ass		

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROVED
STATEMEN	CENTERS FOR MEDICAR FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION AME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE (X4) ID SUMMARY ST PREFIX (EACH DEFICIENCY REGULATORY OR F 278 Continued From particulation order Collection dated Air restraint in use. Medical record revirecapitulation order through October 31 side rails up x (time bed to aid in bedsic self-release belt with to alert staff of unsa Interview with the M for completing the M 9:44 a.m., in the ME assessment had no facility failed to com assessment.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
· <u>-</u> -		445205	B WING_		
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F 278	Continued From particles of Collection dated Algorithm of Collection dated Algorithm of Collection o	age 14 ugust 11, 2012, revealed no iew of the physician's rs dated October 1, 2012, 1, 2012, revealed " 11/28/11 es) 2 bilat (bilateral) while in de positioning 7/22/11 Velcro th alarm to W/C (wheelchair) afe transfer " IDS Coordinator responsible MDS on October 17, 2012, at DS office, confirmed a side rail t been completed and the plete a comprehensive admitted to the facility on th diagnoses including tracture Left Leg. Chronic ary Disease, and	F 278	accurately reflect resident. 3. The facility's Described Services/MDS Conduct QI mon Assessment Conthat the MDS as reflects the statu QI monitoring was weekly for 12 monthly for 9 mesample size of 6 4. The facility's Discribed Services/ Nurse report results of the QA/PI Commendation.	of the APPROPRIATE (CY) Into the status of the coordinator will itoring of MDS inpletion to ensure sessment accurately so of the resident. Fill be conducted 3 weeks then 1 x onths using a contract of Clinical Manager will QI monitoring to inittee monthly x 12 inued compliance
t e r e C re	Data Set (MDS) date the resident had impextremity. Medical re MDS dated August 2 esident had no impaixtremity. Observation on Octo evealed the resident	ber 17, 2012, at 8.30 a.m. seated in a wheelchair, in her observation revealed the			
lr 	nterview on October	17, 2012, at 8:20 a.m., with			

	RS FOR MEDICAR	RE & MEDICAID SERVICES					M APPROVED O. 0938-0391	
STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION JAME OF PROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M ^o A BUII		E CONSTRUCTION	(X3) DATE		
		445205	8 WIN	G		40.	(4.710040	
		₹ E OF CHATTANOOGA		824	EI ADDRESS, CITY, STATE, ZIP CODE 9 STANDIFER GAP ROAD ATTANOOGA, TN 37421	10/17/2012 CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	40 PREFD TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	(OULD BE	COMPLETION DATE	
F 278	Continued From p the MDS Coordina confirmed the MD	age 15 ator #1, in the MDS office, S was not accurate	F 2	78				
	23. 2008, with diag Delusions. Hyperlip Dementia Behavio Esophageal Reflux Medical record revidated July 13, 2013 print, but not regulate books. Corrective magnifying glasses	idmitted to the facility on April gnoses including Senile pidemia, Senile Depression, r. Depressive Disorder, and Diaphragmatic Hernia liew of the quarterly MDS. 2, revealed ". vision-sees farge ar print in newspapers or lenses (contacts, glasses or s) used "No" "						
	Assessment, dated revealed "Visual a Interview with the M October 17, 2012, a confirmed the MDS	September 19, 2009, appliances "Glasses" " IDS Coordinator #1, on at 8:40 a.m., in the MDS office, was inaccurate related to the						
i t r	glasses. Medical record revia Data Set (MDS), da the resident was con equired extensive a daily living. Medical record revia April 21, 2012, revea Z"- None of the abo	ew of the annual Minimum ted July 13, 2012, revealed gnitively impaired and assistance with activities of the annual MDS, dated aled Oral and Dental Status, we were present, related to es, inflamed or bleeding						

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

		A MEDICAID SERVICES					OMB N	<u>0,</u> 0938-039
STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	í	IULTIPLE C LDING	ONS	STRUCTION	(X3) DATE	
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	PROVIDER OR SUPPLIER LATE HEALTH CARE	OF CHATTANOOGA	į	8249 S	TAN	RESS, CITY, STATE, ZIP CODE DIFER GAP ROAD IOOGA, TN 37421	<u>r </u>	17/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(E.	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOUSS-REFERENCED TO THE APPROPRIES.	ULD BE	(X5) COMPLETION DATE
F 278	Continued From pa gums, mouth or fac		F 2	78 F-2	79		-	
SS≂E	Exam, dated Febru "teeth-upper-seve Several broken teet teeth in the lower ar Observation on Oct the resident's room, numerous upper bro Interview with the M 17, 2012, at 8:40 a.t confirmed the MDS 2012, was inaccurai Dental Status and th broken teeth on the 483.20(d), 483.20(k) COMPREHENSIVE A facility must use th to develop, review at comprehensive plan The facility must dev plan for each resider objectives and timeta medical, nursing, and needs that are identi assessment. The care plan must of to be furnished to att highest practicable p psychosocial well-bei	care plans the results of the assessment of revise the resident's of care. Telop a comprehensive care of that includes measurable ables to meet a resident's dimental and psychosocial fied in the comprehensive describe the services that are ain or maintain the resident's hysical, mental, and ong as required under vices that would otherwise	F 27		2.	Residents #46, #84, #102 suffered no harm. The far MDS Coordinator updated #46's care plan to include interventions to address the resident's impaired vision facility's MDS Coordinated Resident #84's care plan to interventions to address defineds. The facility's MDC Coordinator updated Resi 102's care plan to include AV shunt is located in the resident's right arm, and the should be no blood pressured at the resident along with emergency be performed in the event bleeding occurs to the resight arm. The facility's MC Coordinator updated Resignator updated Res	cility's d Resident d Resident de ne d. The or updated to include ischarge S dent # that the there are or nt's right y care to that ident's dent #91's rentions impaired Clinical or/Nurse s ty care plans de needs ent d which	

be required under §483.25 but are not provided

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2012 91

		E & MEDICAID SERVICES			FORM APPROVE
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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445205	B. WING		10/17/2012
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREE	ET ADDRESS, CITY, STATE, ZIP (· · · · · · · · · · · · · · · · · · ·
CONSUL	_ATE HEALTH CARE	OF CHATTANOOGA	824	9 STANDIFER GAP ROAD ATTANOOGA, TN 37421	SODE
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F 279	Continued From pa	nge 17	F 279		
		s exercise of rights under	. 210	their care plans rev	rised to include
	§483.10, including t	the right to refuse treatment		interventions to ad	
	under §483.10(b)(4			The Regional Dire	
				educated the facilit	
	This DEOLUDEMEN	TT is not need to the		Clinical Services a	
	by:	NT is not met as evidenced		Coordinator on the	
		record review, observation,		and Procedure for	
	and interview, the fa	acility failed to develop a care		a Comprehensive C ensure that it include	
	plan to meet the res	sident's needs for four		to address the need	
		, #102, #91) of twenty-seven		The Director of Ch	
		of forty-three sampled		Services/MDS	
	residents.			Coordinator/Educa	
	The findings include	74.		re-educated the cur	
	The mongs moduce	.u.		licensed nursing sta facility's Policy an	
	Resident #46 was a	dmitted to the facility on May		Development of a	
	25, 2012, with diagn	ioses including Hypertension,		Care Plan to ensure	
	End Stage Renal Di	sease, Hepatitis C, Diabetes,		interventions to ad-	
	and Schizophrenia.			of the resident.	
	Medical record regio	ew of the admission Minimum		The facility's Direct	
	Data Set (MDS) date	ed June 1, 2012, revealed the		Services/MDS Coc	
	resident had impaire	ed vision (sees large print, but		conduct QI monito	
	not regular print in n	ewspapers or books), and		resident's compreh to ensure that it inc	
	corrective lens were	not used.		interventions to add	
	Madical record revie	over the Coop Plant A. I.		of the resident. QI	
		w of the Care Plan dated vealed no interventions to		be conducted 3 x w	
	address the resident			weeks using a samp	
	assisse the resident	to unpaired vision,		4. The facility's Direct	
	Observation on Octo	ober 17, 2012, at 10:30 a.m.,		Services/MDS Coo report results of QI	
	revealed the residen	t seated in a geri-chair in the		the QA/PI Commit	
	resident's room. Inte	erview with the resident, at		months for continu	
:	this time, revealed th	ne resident liked to read the		and/or revision	

newspaper. Continued interview revealed the resident was not able to see the newspaper print. and/or revision.

Substantial Compliance 12-1-12

PRINTED: 10/19/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445205 10/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 18 F 279 Interview on October 17, 2012, at 10:10 a.m., with MDS Coordinator #1, in the MDS office. confirmed the Care Plan did not address the resident's impaired vision. Resident #84 was admitted to the facility on August 14, 2012, with diagnoses including Diabetes, Hypertension, Atrial Fibrillation, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease. Medical record review of the Social Services notes dated August 21, 2012, revealed the resident planned to return home after receiving physical and occupational therapy at the facility. Medical record review of the Care Plan dated August 27, 2012, revealed no interventions to address the resident's discharge needs. Interview on October 16, 2012, at 2:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the Care Plan did not address the resident's discharge needs.

Dialysis.

Resident #102 was admitted to the facility on December 31, 2011, with diagnoses including Chronic Kidney Disease Stage IV, Congestive Heart Failure, Coronary Artery Disease, Peripheral Neuropathy, and Renal Failure with

Medical record review of the physician's recapitulation orders dated October 1-31, 2012, revealed physician's orders for emergency care if bleeding occurs to right (R) arm, no labs or blood pressure in (R) arm, and monitor shunt for bruit

		H AND HUMAN SERVICES E & MEDICAID SERVICES				FOR	ED: 10/19/201 RM APPROVEI IO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTIPLE	LE CONSTRUCTION	(X3) DATE	
		445205	8. WIN	1G		10	/17/2012
	PROVIDER OR SUPPLIER			8249	ET ADDRESS, CITY, STATE, ZIP CODE IS STANDIFER GAP ROAD ATTANOOGA, TN 37421		11112012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	10ULD BE	(X5) : COMPLETION DATE
F 279	Continued From pa and thrill every shift		F 2				
	dated May 18, 2012 arm no B/P (blood	riew of the Dialysis Care Plan 2, revealed "AV shunt left d pressure) or sticks in L (left) care if bleeding occurs to L (left)					
	Observation on Oct the resident's room, was located in the r	stober 17, 2012, at 9:49 a.m., in not revealed the dialysis shunt right arm.					
	Registered Nurse #	er 17, 2012, at 9:53 a.m., with #2 at the West nursing station, sis shunt was located in the					
	the Director of Clinic	er 17, 2012, at 9:55 a.m., with cal Services in the Care Plan e care plan was incorrect f the dialysis shunt.					
	October 2, 2010, wit	admitted to the facility on ith diagnoses including Muscle stive Heart Failure, Diabetes, Behavior,					
	Data Set (MDS) data revealed the residen Medical record revie	ew of the Quarterly Minimum ted February 20, 2012, int had adequate vision. ew of the Significant Change ated August 4, 2012, revealed paired vision.					

Medical record review of the care plan dated August 13, 2012, revealed no documentation of

the resident's impaired vision.

PRINTED: TUTT9/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445205 10/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 279 Continued From page 20 F 279 Interview on October 16, 2012, at 4:45 p.m., with F-313 the MDS Coordinator #1, in the MDS office. confirmed the care plan had not been developed Resident #46 suffered no harm. for the resident's impaired vision. Resident #46 was seen by the F 313 483.25(b) TREATMENT/DEVICES TO MAINTAIN F 313 Optometrist on 10-25-12 for an eye SS=D HEARING/VISION exam. 2. The facility's Director of Clinical To ensure that residents receive proper treatment Services/Social Services Director reviewed all current facility and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, residents to ensure that they had an assist the resident in making appointments, and eye exam in the past year. Any by arranging for transportation to and from the residents identified as not having office of a practitioner specializing in the had an eye exam in the past year treatment of vision or hearing impairment or the were referred to the Optometrist for office of a professional specializing in the an eye exam, as applicable. The provision of vision or hearing assistive devices. Regional Director of Clinical Services re-educated the facility's Director of Clinical Services and This REQUIREMENT is not met as evidenced Social Services Director on the facility's Policy and Procedure for Based on medical record review, observation. the Provision of Vision Services to and interview, the facility failed to obtain vision ensure that residents have an eye services for one resident (#46) of three residents exam yearly. The facility's reviewed of forty-three sampled residents. Director of Clinical Services/Social Services Director/Education The findings included: Coordinator re-educated licensed nursing staff on the facility's Policy Resident #46 was admitted to the facility on May and Procedure for the Provision of 25, 2012, with diagnoses including Hypertension, Vision Services to ensure that

and Schizophrenia.

End Stage Renal Disease, Hepatitis C. Diabetes,

Medical record review of the admission Minimum.

resident had impaired vision (sees large print, but

not regular print in newspapers or books), and

Data Set dated June 1, 2012, revealed the

corrective lens were not used.

residents have an eye exam yearly.

3. The facility's Director of Clinical Services/Social Services Director

will conduct QI monitoring of

residents have had an eve exam

within the past year. QI monitoring

will be conducted 3 x weekly for 12

vision services to ensure that

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 10/19/2012 1 APPROVED 2. 0938-0391
STATÉMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTI	RUCTION	(X3) DATE S	SURVEY
		445205	B. WING			10/-	17/2012
	PROVIDER OR SUPPLIER	OF CHATTANOOGA	1	8249 STAND	SS, CITY, STATE, ZIP CODE IFER GAP ROAD DOGA, TN 37421	<u> </u>	1772012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Pi (EAC	ROVIDER'S PLAN OF CORRECTH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 313	Continued From pa		F 313	3	<u> </u>	 -	
	Medical record reviet the resident had record continuous continuou	ew revealed no documentation beived an eye examination. ober 17, 2012, at 10:30 a.m., at seated in a geri-chair in the erview with the resident, at the resident liked to read the used interview revealed the e to see the newspaper print.			weeks then 1 x monthly months. The facility's Director of Services/Social Services will report results of QI to the QA/PI Committee 12 months for continued compliance and/or revision Substantial Compliance	f Clinical Director monitoring monthly x	
F 332	with the Customer C services office, conf been referred for an 483 25(m)(1) FREE	OF MEDICATION ERROR	F 332	F- 332	Residents # 14, #16, and		
35-17	RATES OF 5% OR I The facility must ensinedication error rate				suffered no harm. Reside Nurse Practitioner was no medication error on 10-1 new orders were given, re and implemented. Reside Conservator was notified	otified of 5-12 and eceived, ent #14's	
	by: Based on medical refacility policy review, failed to properly adn fifty-six opportunities medication error rate The findings included Resident # 14 was ac November 3, 2009, w				medication error on 10-1 Resident #14's nurse was educated/counseled on 10 Resident #16's Nurse Pra was notified of medicatio 10-16-12 and new orders given, received, and impl Resident #16's Conserva notified of medication err 16-12. Resident #16's contaminated eye medication discarded and replaced whother of eye medication. #16's nurse was reeducated/counseled on 10 reducated/counseled on 10 reducated/co	s re- 0-15-12. actitioner on error on were lemented. tor was ror on 10- ation was rith a new Resident	

Medical record review of the monthly physician's

Resident #86's Nurse Practitioner

CENTERS FOR MEDICARE		E & MEDICAID SERVICES		<u>. 0938-0391</u>				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	MULTIPLE (CONST	RUCTION	(X3) DATE S COMPLE	
		445205	B. WI	NG			10/1	7/2012
	PROVIDER OR SUPPLIER LATE HEALTH CARE	OF CHATTANOOGA	•	8249 5	STAND	ESS, CITY, STATE, ZIP CODE DIFER GAP ROAD DOGA, TN 37421	.1.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	PREFIX (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 332	revealed "Lantus (subcutaneous) twi FSBS (finger stick I scale) BID (twice da	rs dated October 1-31, 2012, (insulin) 13 units Sub-Q ce dailyHumalog (insulin) blood sugar) with SS (sliding aily)"	F	332		was notified of medication 10-16-12 and new orders given, received, and imp Resident #86's Responsion was notified of medication 10-16-12. Resident #86	were lemented. ble Party on error on	:
	Observation on October 15, 2012, at 4:22 p.m., in the resident's room, revealed Registered Nurse (RN) #1 administered Humalog three units in a syringe mixed with Lantus thirteen units in the right arm of resident #14. Facility policy review of Injectable Insulin Checklist revealed ". mixing of insulins Eanutus should not be mixed with other insulins . failure to adhere to the procedure may result in a loss of blood sugar control."				2.	was re-educated/counseled on 10- 16-12.		
	4:30 p.m., in the 20 insulins were mixed same syringe Interview with the D 15, 2012, at 4:44 p.i confirmed the insulitogether. Resident # 95 was a September 3, 2012,	1 on October 15, 2012, at 0 hallway, confirmed the land given together in the lirector of Nursing on October m., in the conference room, in was not to be administered admitted to the facility on with diagnoses including la, and Hypertension.				intervention, as well as a made to the Responsible applicable. Facility nurs identified as not having a medications appropriatel immediately re-educated. The facility's Director of Services/Education Cooreducated all current Lice. Nursing Staff on the facility and Procedure for Medication Administrate medications are being ad properly.	Party, as es given y were /counseled. f Clinical dinator re- nsed lity's or to ensure	
	recapitulation orders	ew of the monthly physician's dated October 1-31, 2012, (eye drops for glaucoma) one lice daily. "			3.	The facility's Director of Services/Nurse Manager conduct QI monitoring o Medication Administrations and administered properly.	will f on to are	

Observation on October 16, 2012, at 8:56 a m., in

		H AND HUMAN SERVICES E & MEDICAID SERVICES					FORM): 10/19/201 MAPPROVE): 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A. BUIL		CON	STRUCTION	(X3) DATE S	SURVEY
		445205	B. WIN	G			10/:	17/2012
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADD	RESS, CITY, STATE, ZIP CODE		1772012
CONSU	LATE HEALTH CARE			8249	STAN	NDIFER GAP ROAD NOOGA, TN 37421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	(E CRC	PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH OSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 332	Continued From pa		F 3:	32				:
	Nurse (LPN) #1 ad and the dropper waduct.	n, revealed Licensed Practical ministered Trusopt to each eye as placed in the residents tear				monitoring will be condi- weekly for 4 weeks, then weekly for 4 weeks, then weekly for 4 weeks, then monthly for 9 months us	13 x n 1 x 1 1 x	:
	Facility policy revie dated January 200 away from the eyel	w of Eye Drop Administration 7. revealed "draw lower lid				sample size of 5 (two numonitored on 7-3 shift at	rses are to nd 3-11	
	pocketdrop the se	plution into the middle of the uch eye with dropper"			4.	Services/Nurse Manager	f Clinical will report	
	9:00 a m., in the 20 dropper was placed Continued interview #1 was unable to de	#1 on October 16, 2012, at 0 hallway, confirmed the 1 in the resident's tear duct. If at this time confirmed LPN etermine the amount of				results of QI monitoring QA/PI Committee month months for continued con and/or revision. Substantial Compliance	nly x 12 mpliance	
	revealed Registered medications for resi order to crush the m Propranolol HCL (H (milligrams) for bloo crushed medication	ober 16, 2012, at 4:23 p.m., d. Nurse (RN) #3 placed dent #86 in a plastic pouch, in nedications, including ydrochloride) 20 mg d pressure, placed the s in applesauce, and edications to the resident in						
	the resident's room, Propranolol HCL 20	at the medication cart outside revealed one-half of the mg pill had been left inside s not administered to the						

Review of the physician's recapitulation orders dated October 1-31, 2012, revealed a physician's order for Propranolol HCL 20 mg take one tablet

resident.

PRINTED: 10/19/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING B. WING 445205 10/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙĎ (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION). TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 332 Continued From page 24 F 332 by mouth twice daily. F-333 Interview on October 16, 2012, at 4:40 p.m., with Resident #14 suffered no harm. RN #3 at the medication cart in the hallway. Resident #14's Nurse Practitioner confirmed one-half of the Propranolol HCL 20 mg was notified of medication error on tablet was left in the package and had not been 10-15-12 and new orders were administered to the resident. given, received, and implemented. F 333 483.25(m)(2) RESIDENTS FREE OF F 333 Resident #14's Conservator was SS=D SIGNIFICANT MED ERRORS notified of medication error on 10-15-12. Resident #14's nurse was The facility must ensure that residents are free of re-educated/counseled on 10-15-12. any significant medication errors 2. The facility's Director of Clinical Services/Nurse Manager reviewed all current residents to ensure that This REQUIREMENT is not met as evidenced. no residents had a significant medication error in the past 30 Based on medical record review, observation, days. Any current residents review of facility policy, and interview, the facility identified as having a significant failed to prevent a significant medication error for medication error in the past 30 days one resident (#14) of twelve sampled residents had their Physician notified for any further intervention, as well as The findings included: notification to the Responsible Party, as applicable. Facility nurses Resident # 14 was admitted to the facility on identified as having made a November 3, 2009, with diagnoses including significant medication error were Diabetes Mellitus Type II. Hypertension, and immediately re-educated/counseled. Senile Dementia Additionally, the facility's Director of Clinical Servicers/Nurse Medical record review of the monthly physician's Manager reviewed all diabetic recapitulation orders dated October 1, 2012, residents to ensure that any with through October 31, 2012, revealed "...Lantus physician's orders for Lantus or (insulin) 13 units Sub-Q (subcutaneous) twice Levemir had indicated on their daily...Humalog (insulin) FSBS (finger stick blood

sugar) with SS (sliding scale) BID (twice daily)..."

Observation on October 15, 2012, at 4:22 p.m., in

the residents room, revealed Registered Nurse

(RN) #1 administered Humalog three units in a

Medication Administration Record

Levemir with Any Other Insulins."

Any current diabetic residents with

(MAR) the following statement, "Do Not Mix Lantus and/or

PRINTED: 10/19/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING B WING 445205 10/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 333 Continued From page 25 F 333 syringe mixed with Lantus thirteen units in the physician's orders for Lantus and/or right arm of resident #14. Levemir identified as not having this statement indicated on their Facility policy review of Injectable Insulin MAR, had this statement added to Checklist revealed "...mixing of insulins . Lanutus their MAR and notification was should not be mixed with other insulins failure to made to the pharmacy. The adhere to the procedure may result in a loss of facility's Director of Clinical blood sugar control..." Services/Education Coordinator reeducated all current facility Interview with RN #1 on October 15, 2012, at Licensed Nursing Staff on the 4:30 p.m., in the 200 hallway, confirmed the facility's Policy and Procedure for insulins were mixed and given together in the Medication Administration to same syringe. ensure prevention of significant medication errors as well as the Interview with the Director of Nursing on October proper administration of Lantus and 15, 2012, at 4:44 p.m., in the conference room. Levemir, as they are not to be confirmed the insulin was not to be administered mixed with any other insulins. together 3. The facility's Director of Clinical F 371 483.35(i) FOOD PROCURE. F 371 Services/Nurse Manager will SS=F STORE/PREPARE/SERVE - SANITARY conduct QI monitoring of Medication Administration The facility must including Lantus and Levemir (1) Procure food from sources approved or administration to ensure prevention considered satisfactory by Federal, State or local of significant medication errors. QI authorities; and monitoring will be conducted 5 x (2) Store, prepare, distribute and serve food weekly for 4 weeks, then 3 x under sanitary conditions weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months using a sample size of 5 (two nurses are to

FORM CMS-2567(02-99) Previous Versions Obsolete

This REQUIREMENT is not met as evidenced

Based on observation, facility policy review, and

leftovers in the dietary department, facility staff failed to wash the hands appropriately in the

interview, the facility failed to timely discard

Event ID R9ZZ11

Facility ID TN3314

If continuation sheet Page 26 of 34

be monitored on 7-3 shift and 3-11 shift and one nurse on 11-7 shift).

4. The facility's Director of Clinical Services/Nurse Manager will report

results of QI monitoring to the

QA/PI Committee monthly x 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES	C				OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL1 A. BUILDII	TIPLE CONST	RUCTION	(X3) DATE SU COMPLE		
		445205	B. WING			10/1	7/2012	
	ROVIDER OR SUPPLIER	OF CHATTANOOGA		8249 STAND	ESS, CITY, STATE, ZIP CODE DIFER GAP ROAD OOGA, TN 37421			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
F 371	Continued From pa	age 26	F 371					
	dietary department, failed to ensure t machine was maintained in a clean of failed to ensure the appropriate temp				months for continued co and/or revision.	mpliance		
	food was maintaine	ed.			Substantial Compliance	12-1-12		
	The findings includ	ed:		F-371				
	Observation on October 15, 2012, from 9:55 a.m., through 10:30 a.m., with the Certified Dietary Manager (CDM) revealed the following: located in the walk-in refrigerator approximately one and one half cups of egg salad, dated to be discarded on October 13, 2012, and available for use; the CDM, opened the dumpster outside the facility, reentered the dietary department, and without washing the hands touched the clean pans on the drying rack; and the ice machine had black debris inside the ice machine directly above the ice supply. Observation on October 15, 2012, at 11:45, of the tray line in the dining room, revealed the temperature of the crab cakes was 110 degrees F (farhenheit). Review of the facility's policy Leftover Utilization revealed "Leftovers are utilized within 48 hours"			2.	harm. The facility's Cer Dietary Manager immed discarded the egg salad of 12. The facility's Certiff Manager immediately repan for sanitizing and with hands on 10-15-12. The Certified Dietary Manage immediately cleaned the machine on 10-15-12. The Certified Dietary Manage immediately removed the cakes and replaced them cakes and replaced them cakes at the appropriate of 160 degrees Fahrenhee The facility's Certified Dietary Manager/Registered Dietary Manager/Registered Dietary Manager/Registered Dietary washes their hands appropriate to ensure that the ice machine is min a clean condition, and is maintained at the appropriate and the dietary of the machine is maintained at the dietary of the machine is maintained in the dietary of the machine is maintained at the appropriate of the dietary of the machine is maintained in the dietary of the machine is maintained in the dietary of the machine is maintained in the dietary of the machine is maintained in the dietary of the machine is maintained in the dietary of the machine is maintained at the appropriated to leftovers being	rtified liately on 10-15- ied Dietary moved the ashed her e facility's er e ice he facility's er le crab a with crab temperature eit. Dietary etician ietary at leftover that staff opriately, naintained that food ropriate nees department discarded		
	following timesaft Review of the facilit revealed "Ice mus				temperature. Any varian identified in the dietary of	nces departme g discarde eir hands	ed	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

OFILE	TO LOIS MEDICATE	A MICDICAID SELVICES				<u> </u>	-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A BUILI		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		445205	B WING	3		10/17/2012	2
NAME OF	PROVIDER OR SUPPLIER] ;		DRESS, CITY, STATE, ZIP CODE		
CONSU	LATE HEALTH CARE	OF CHATTANOOGA			NDIFER GAP ROAD NOOGA, TN 37421		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES		01174117			
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F 371	Continued From pa	ge 27	F 37	71			
F 412	Review of the facility Guidelines revealed foods at temperature below 40 degrees Function Interviews on October through 10:30 a.m., department, confirm discarded timely, the after touching the dictional clean pans, the ice the temperature of temperature of temperature of the temperature of temperature of temperature of temperature of	y's policy Food Handling 3"Hold potentially hazardous res above 140 degrees F and" per 15, 2012, from 9:55 a.m., with the CDM, in the dietary ned the egg salad was not e hands were not washed umpster prior to touching the machine was not clean, and the crab cakes was 110 E/EMERGENCY DENTAL must provide or obtain from , in accordance with ert, routine (to the extent state plan); and emergency reet the needs of each cessary, assist the resident in ts; and by arranging for d from the dentist's office, and residents with lost or o a dentist. T is not met as evidenced ecord review, observation cility failed to obtain routine wo residents (#6, #1) of	F 37		being maintained in a clear condition, and/or food being maintained at the appropriemperature, was immediated addressed by the facility? Dietary Manager/Register Dietician and dietary staff immediately re-educated/accordingly. The Register Dietician re-educated the Certified Dietary Manager facility's Policy and Proceute Food Utilization washing, Equipment Clear Requirements (including schedules), and Food Ten Requirements at Point of (including measures to sure holding temperatures) to food is stored, prepared a under sanitary conditions. facility's Certified Dietar Manager/Education Cooreducated all current facilistaff on the facility's Poliprocedure for Leftover For Utilization, Hand washing Equipment Cleaning Requipment Cleaning Requipment Cleaning sched Food Temperature Requipment of Service (including measures to support holditemperatures) to ensure for stored, prepared and servered.	ing iate ately s Certified red f were counseled, ered facility's r on the edure for , Hand ning cleaning nperature Service pport ensure that nd served . The y dinator re- ty dietary cy and bod et inements ules), and rements at g ing bod is	
	resident's.	ewed of forty three sampled		3	sanitary conditions. The facility's Certified D Manager/Registered Diet		
	The findings included	d:			- -		

PRINTED: 10/19/2012

DLIAN	CONTINUE OF THE METER	TAND HOMAN SERVICES			FORM	LAPPROVE
_CENTE!	RS FOR MEDICARI	E & MEDICAID SERVICES				. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		NCIES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		445205	B. WING) 10/1	7/2012
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STAT		112012
CONSUL	ATE HEALTH CARE	OF CHATTANOOGA	824	9 STANDIFER GAP ROA ATTANOOGA, TN 37	AD	
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F 412	Continued From pa	age 28	F 412			
	23, 2008, with diag Delusions, Hyperlip Dementia Behavior Esophageal Reflux Medical record reviews, dated Febru "teethupper sevieweral broken teet Center for Oral and Medical record reviewed Record revealed "confered daughter resident	ew of the Care Plan f, dated January 5, 2012,		dietary depa leftover food that staff wa appropriately is maintained and that food appropriate to monitoring weekly for 4 weekly for 4 weekly for 4 monthly for 4. The facility' Manager/Re report results the QA/PI C	s Certified Dietary gistered Dietician will s of QI monitoring to committee monthly x 12 continued compliance	
	April 26, 2012, revedentationis dependent carearrange follow	ew of the Care Plan, dated caled " has poor ident on staff for oral with dentist."		Substantial (Compliance 12-1-12	
	progress notes, dat "Dr (physicians na go to a dentist office looked at because i facilityhowever, (re	ew of the social service ed January 5, 2102, revealed ame) recommended resident e for cleaning and to get teeth t cannot be done in the esident's family) does not sportationsocial worker will st"		Resident #6 see an oral s' the Social Se arranged trat #1 was seen 19-12. 2. The facility' Services/Nur Service Dire	S suffered no harm. has an appointment to urgeon on 11-7-12 and ervices Director has esportation. Resident by the dentist on 10- s Director of Clinical erse Manager/Social ector reviewed all ity residents to ensure	

Telephone interview with the resident's family member on October 17, 2012, at 11:10 a.m.,

revealed the resident had numerous broken teeth

that they had received dental services in the past year and/or any

PRINTED: 10/19/2012 ED

		I AND HUMAN SERVICES 8 MEDICAID SERVICES				FORM	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		445205	B WIN	lG		10/	17/2012
CONSU	PROVIDER OR SUPPLIER		- 1 ···	8249 STA	ORESS, CITY, STATE, ZIP COD NDIFER GAP ROAD NOOGA, TN 37421		1112012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	X (I	PROVIDER'S PLAN OF CORI EACH CORRECTIVE ACTION (OSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	Continued From page 29 and an appointment with a dental surgeon had been made. Continued interview revealed "the facility called me and told me they could not arrange transport by ambulance for the residentresident is in a geri-chair and we cannot get the chair in the vehicle and we need an ambulancethe appointment was cancelled and never rescheduled" Interview with the Social Service Director on October 17, 2012, at 1:00 p.m., in the East Nurses Station, confirmed the facility failed to follow up on the appointment and arrange transportation for the resident. Resident #1 was admitted to the facility on July 23, 2002, and readmitted July 22, 2011, with diagnoses including Dementia, Anxiety. Left hemiparesis, and Anemia. Medical record review of the annual MDS dated February 27, 2012, revealed no dental problems. Medical record review of the Care Plan dated March 6, 2012, revealed "poor dentation, will have adequate oral care providedarrange follow up appointments with dentist" Observation on October 15, 2012, at 2:30 p.m., in the resident's room, revealed the resident seated in a reclining wheelchair, self release seat belt in lace, and teeth in poor condition.		F 4	reeded follow-up services had been current facility res as not having rece services and/or any up for dental servi appointment sched dentist, as applicated Director of Clinical Educated the facility Clinical Services and Director of Social facility's Policy and Provision of Dentate facility's Director Services/Director Services/Education educated all current Department Managuell as all current the facility's Policy for the Provision of Services. The facility's Director Services.		completed. Any dents identified ved dental needed follow ses had an uled to see the le. The Regional I Services re- y's Director of nd facility's Services on the d Procedure for I Services. The of Clinical f Social Coordinator re- t facility ement staff, as tursing staff on and Procedure Dental tor of Clinical vices Director nitoring to residents receive ast yearly and/or	
	Interview with the Social Service Director on				weekly for 4 weeks, the weekly for 8 weeks, the monthly for 9 months t	en 1 x	

October 16, 2012, at 3:33 p.m., in the resident's

room, confirmed the resident had not been seen

consult available in the medical record, and the

by the dentist since March 2011, no dental

sample size of 6.

4. The facility's Director of Clinical

Services/Social Services Director

PRINTED: 10/19/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING B WING 445205 10/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID

F 412 Continued From page 30 facility failed to provide routine dental services. F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

PREFIX

TAG

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission. of disease and infection.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

- (a) Infection Control Program The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility:
- (2) Decides what procedures, such as isolation. should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
- (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

F 412

F 441

PREFIX

TAG

will report results of QI monitoring to the OA/PI Committee monthly x 12 months for continued compliance and/or revision.

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

Substantial Compliance 12-1-12

(X5)

COMPLETION

DATE

F-441

- Residents #14, #114, and #16 suffered no harm. The ice container was immediately emptied, sanitized and an ice scoop with a holder was placed on the cart on 10-15-12. The blood glucose basket and medication cart were cleaned on 10-16-12. Resident #16's Nurse Practitioner was notified of medication error on 10-16-12 and new orders were given, received, and implemented. Resident #16's contaminated eye medication was discarded and replaced with a new bottle of eye medication. Resident #16's nurse was re-educated/ counseled on 10-17-12. The nurse who disposed of the lancet in the trash was re-educated/counseled on 10-15-12.
- The facility's Director of Clinical Services/Nurse Manager reviewed all current facility residents to ensure that infection control practices were being followed during blood glucose monitoring, medication administration, and lunch tray delivery. Any current

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID R9ZZ11

Facility ID: TN3314

If continuation sheet Page 31 of 34

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVI		
		& MEDICAID SERVICES). 0938-039		
i -		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		445205	B. WII	N G		10/	17/2012		
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE				
CONSU	LATE HEALTH CARE	OF CHATTANOOGA		82	249 STANDIFER GAP ROAD HATTANOOGA, TN 37421				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 441	Continued From pa	ge 31	F۷	141					
	by: Based on observation and interview, the facontrol practices during medication administration administration, and four halls. The findings include Observation on Octoon the 100 hall, during revealed Certified Nobtained ice with a continuous delivered a mean observation revealed the same cup left in dropped the cup in the meal tray to a reside Interview on October the 100 hall, with Lic (LPN), confirmed the infection control practices.	ober 15, 2012, at 12:05 p.m., ng the lunch tray delivery, ursing Assistant (CNA) #2 cup from a plastic bow! ves), dropped the cup in the I tray to a resident. Continued d CNA #3 obtained ice with the ice from the plastic bow!, he ice, and delivered the ent. r 15, 2012, at 12:10 p.m., on ensed Practical Nurse #4 c CNA's failed to follow			facility residents identification compractices followed during glucose monitoring, mediadministration and/or lut delivery were addressed immediately and involve immediately re-educated. The facility's Director of Services/Education Cooreducated all current facility staff on the facility's Pol Procedure for Infection Corelated to blood glucose medication administration lunch tray delivery, as an 3. The facility's Director of Services/Nurse Manager conduct QI monitoring control practices as relat glucose monitoring, mediadministration, and lunch delivery. QI monitoring conducted 5 x weekly for 4 weeks, the monthly for 9 months. 4. The facility's Director of Services/Nurse Manager results of QI monitoring QA/PI Committee month months for continued co and/or revision.	atrol g blood dication nch tray ed staff was d/counseled. f Clinical redinator re- lity nursing licy and Control as monitoring, on, and pplicable. f Clinical r will of infection lication h tray g will be or 4 weeks, liceks, then 1 licen 1 x f Clinical r will report to the hly x 12			

revealed Registered Nurse (RN) #1 retrieved a

basket of blood glucose monitoring supplies from the medication room, entered resident #114's room, placed the basket on the resident's bedside Substantial Compliance 12-1-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445205	B. WIN	IG	· ····	10/	17/2012
	PROVIDER OR SUPPLIER	OF CHATTANOOGA		8249	T ADDRESS, CITY, STATE, ZIP CODE STANDIFER GAP ROAD ATTANOOGA, TN 37421	,	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	table without a prot blood glucose for the in a chair in the root and placed the base. Further observation entered resident #1 on the resident's be protective barrier, preceded the resident's on the medication of the medication	dective barrier, performed a me resident, placed the basket m, exited the resident's room, ket on the medication cart. In at this time revealed RN #1 4's room, placed the basket edside table without a performed the blood glucose, is room, and placed the basket eart. Director of Nursing (DON) on at 10:30 p.m., in the DON protective barrier was to be asket and confirmed the facility etion control practice during itoring. Tober 15, 2012, at 4:22 p.m., formed a finger stick to obtain resident #14. Continued at RN #1 placed the lancet are finger stick, on the wax and glucose. Further the lancet enclosed, and the glove as the RN removed and observation at this time acced the lancet (sharps) inside the can. Director of Nursing (DON) on the total transfer was to be asket and confirmed the facility etion control practice during itoring.	F 4	41			
	handled and dispos prevent the transmi- organismssharps	, revealed "sharpsshall be ed of in a safe mannerto ssion of blood borne shall be placed directly into a ant container after use"					

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 10/19/2012 M APPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		445205	B. WIN	iG		10/	17/2012	
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF CHATTANOOGA				8249	ADDRESS, CITY, STATE, ZIP CODE STANDIFER GAP ROAD TTANOOGA, TN 37421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x :	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	ON SHOULD BE COMPLETION BAPPROPRIATE DATE		
F 441	Continued From page	ge 33	F 4	41				
	4:22 p.m., confirmed disposed of properly Interview with the Di 10:30 a.m., in the Di facility failed to disposmanner. Observation on Octo	1 on October 15, 2012, at d the lancet had not been y in the sharps container. ON on October 17, 2012, at ON office, confirmed the ose of sharps in a safe ober 16, 2012, at 8:56 a.m., in revealed Licensed Practical						
	Nurse (LPN) #1 adm for glaucoma) to each	ninistered Trusopt (eye drops th eye and the dropper was nts tear duct at instillation dropper between						
	Review of facility polidated January 2007, eye with dropper"	icy Eye Drop Administration revealed "Do not touch						
	October 16, 2012, at hallway, confirmed in	ensed Practical Nurse #1 on 9:00 a.m., in the 200 fection control practice was estillation of eye drops.						